EDMUND G. BROWN JR.
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
ELENA L. ALMANZO
Deputy Attorney General
State Bar No. 131058
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 322-5524
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PAMELA RENEE TEETS** **18002 N. 40th Place, Apt. 109** **Phoenix, AZ 85032** **Registered Nurse License No. 570383** Respondent.	Case No. 2011-98 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 16, 2000, the Board issued Registered Nurse License Number 570383 to Pamela Renee Teets ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2012, unless renewed.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

///

license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

COST RECOVERY

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Disciplinary Actions by the Arizona State Board of Nursing)

7. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Arizona State Board of Nursing (hereinafter "Arizona Board"), as follows:

a. On or about July 28, 2008, pursuant to Consent Agreement and Order No. 0708008 in the disciplinary proceeding titled *In the matter of Professional Nurse License No. RN 107237 Issued to: Pamela Renee Teets*, the Arizona Board revoked Respondent's license to practice professional nursing in that state. The Board ordered that the revocation would be stayed for as

long as Respondent remained in compliance with the Order and that during the stay of the revocation, Respondent's professional nurse license would be placed on suspension indefinitely until she completed certain terms and conditions, followed by probation for 24 months. A true and correct copy of the Consent Agreement and Order is attached hereto as exhibit A and incorporated herein by reference. Respondent admitted, in substance, as follows:

1. Respondent was employed at Life Care Center of Paradise Valley, Paradise Valley, Arizona, from approximately February 22, 2006, to September 17, 2006. On or about June 9, 2006, Respondent was given a verbal warning for leaving a resident's medication at the bedside and asking the certified nursing assistant to administer the medication to the resident. On or about July 29, 2006, Respondent administered an incorrect medication to a resident, failed to promptly report the medication error, and failed to follow the appropriate policy and procedure for medication administration, resulting in the medication error. On or about September 21, 2006, Respondent failed to administer the correct medication to a resident and failed to follow the correct policy and procedures regarding medication administration.

2. Respondent was employed at Ridgecrest Healthcare, Phoenix, Arizona, from approximately October 20, 2006, to March 1, 2007. Respondent's employment was voluntarily terminated for multiple narcotic discrepancies and failure to provide notice or adequate notice.

3. Respondent was employed at Healthsouth Scottsdale Rehabilitation Hospital, Scottsdale Arizona, from approximately May 10, 2007, to July 9, 2007. On or about June 11, 2007, Respondent failed to create new Medication Administration Records ("MAR") for a patient. As a result, all of the patient's medications were signed as administered on the wrong day. On or about June 11, 2007, an incident report was completed, reflecting that Respondent failed to transcribe new medication orders for a patient. As a result, the patient did not receive the ordered medication for a 24 hour period. On or about July 7, 2007, the charge nurse received multiple complaints from patients regarding Respondent's nursing care, including that Respondent gave a patient the wrong medication, and placed Norco on another patient's bedside table when the patient was supposed to receive Percocet (the patient reported that he had not received any pain medications all night aside from the Norco), After a review of Respondent's

assignments, additional errors were identified, including that Respondent placed MAR's in the wrong patient rooms and medical records/charts, and failed to administer medications. The charge nurse reported that Respondent was unable to focus her thoughts on any one task at a time for any amount of time, her thoughts seemed scattered, and she failed to complete any of the tasks required to take care of her patients. Respondent was relieved of her duties due to her inability to provide safe care to her assigned patients.

4. Respondent was employed at Brighton Gardens in Sun City, Arizona, from approximately July 30, 2007, until August 7, 2007. Respondent was terminated from her employment due to narcotic discrepancies involving Ativan, oxycodone, Vicodin, and Xanax (alprazolam).

5. On and between April 22, 2008, and April 24, 2008, Respondent underwent a neuropsychological and substance abuse evaluation by Scott Sindelar, Ph.D. pursuant to an Interim Order issued by the Arizona Board. The evaluation showed Respondent's neurological status to be in the normal range with a mildly impaired ability to solve problems and to think in abstract terms. Dr. Sindelar reported that Respondent had possible addiction issues, and recommended that Respondent have one physician be aware of all of the medications she was taking and that an addiction specialist monitor her pain medications carefully.

6. On or about October 1, 2007, Respondent was employed with Maxim Staffing Solutions ("Maxim") with an assignment at John C. Lincoln, North Mountain, Phoenix, Arizona. On or about April 4, 2008, Board staff received a complaint from the Accounts Manager at Maxim, indicating that Respondent displayed unusual behavior during her March 30, 2008, shift at John C. Lincoln. Respondent's movements were slow and uncoordinated, she nodded off while in conversation, was witnessed to have glassy eyes, and asked disjointed questions. On or about March 29, 2008, Respondent was assigned to care for three patients. In reviewing Respondent's documentation, it was discovered that Respondent pre-charted her assessment of all three patients, failed to document giving patient E.E. his dose of Solumedrol at 2000 hours when it was required, and documented in another patient's chart a one line narrative, "Right hand I&D with complaints. Extremity wrapped with Morphine" (the patient told the night nurse that he had not

received medications for pain since 22:30 hours). The charge nurse instructed the floor staff not to allow Respondent any further contact with patients. Respondent was escorted off of the unit. Later, Respondent's personal belongings were brought to the charge nurse's office, including Respondent's backpack. Respondent's backpack was opened and the charge nurse saw a syringe-less needle with a green hub, which was not the type of needle that was stocked at John C. Lincoln. On or about March 30, 2008, Respondent submitted to a "for cause" drug screen and tested positive for Demerol, morphine, and oxycodone. Respondent provided a prescription for the morphine and oxycodone, but did not have a valid prescription for the Demerol.

7. A review of Respondent's prescription profile showed that between April 2007, and October 2007, Respondent received approximately 468 oxycodone ER 20 mg capsules and 565 oxycodone 5 mg capsules.

b. On or about August 28, 2009, pursuant to the Notice of Revocation in the above-referenced disciplinary proceeding, the Arizona Board revoked Respondent's Professional Nurse License No. 107237 due to her failure to comply with the provisions of the Consent Agreement and Order. Respondent failed to submit, or cause her medical provider(s) to submit, documentation regarding her narcotic and/or other controlled substance prescriptions. Specifically, Respondent had tested positive for benzodiazepines and oxycodone multiple times over a period of a few months; however, the Board did not receive ongoing documentation indicating the need for these medications. A true and correct copy of the Notice of Revocation is attached hereto as exhibit B and incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 570383, issued to Pamela Renee Teets;

2. Ordering Pamela Renee Teets to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/16/10

for LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010101021
10578568.doc

EXHIBIT A

CONSENT AGREEMENT AND ORDER

ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN107237 ISSUED TO: PAMELA RENEE TEETS, RESPONDENT	)	CONSENT AGREEMENT AND ORDER NO. 0708008

A complaint charging Pamela Renee Teets ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a settlement of the above-captioned matter, consistent with the public interest, statutory requirements and the responsibilities of the Board, and pursuant to A.R.S. § 41-1092.07 (F)(5), the undersigned parties enter into this Consent Agreement and Order ("Order") as a final disposition of this matter.

Based on the evidence before it, the Board makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Pamela Renee Teets ("Respondent") holds Board issued professional nurse license no. RN107237 in the State of Arizona.

2. From on or about February 22, 2006 until September 17, 2006, Respondent was employed at Life Care Center of Paradise Valley in Paradise Valley, Arizona.

3. On or about May 31, 2006, an action plan was established to address Respondent's absenteeism, attendance at monthly nursing meetings, negative disposition and Respondent's supervision of the night shift staff.

4. On or about June 9, 2006, Respondent was given a verbal warning for leaving a resident's medication at the bedside and asking the certified nursing assistant to administer the medication to the resident.

5. On or about July 29, 2006, Respondent administered an incorrect medication to a resident, failed to promptly report the medication error in a timely manner then did not follow the appropriate policy and procedure for medication administration thus resulting in a medication error. An action plan was established on or about August 8, 2006 to prevent these incidents from reoccurring.

6. On or about September 21, 2006, it was identified that Respondent did not meet the expectations of the August 8, 2006 action plan within the time frame established. Respondent failed to administer the correct medication to a resident and did not follow the correct policy and procedures regarding medication administration.

7. On or about September 22, 2006, Respondent's employment was terminated for unsafe practice and is not eligible for rehire.

8. From on or about October 20, 2006 until March 1, 2007, Respondent was employed at Ridgecrest Healthcare in Phoenix, Arizona.

9. On or about March 2, 2007, Respondent's employment was voluntarily terminated for multiple narcotic discrepancies and no notice/inadequate notice.

10. From on or about July 12, 1999 until September 20, 1999 and again from March 12, 2007 until April 8, 2007, Respondent was employed at Banner Thunderbird Medical Center in Glendale, Arizona. During both periods of employment, Respondent was terminated for failing to successfully complete the conditional period.

11. From on or about May 10, 2007 until July 9, 2007, Respondent was employed at Healthsouth Scottsdale Rehabilitation Hospital in Scottsdale, Arizona.

12. On or about May 28, 2007, an incident report was completed reflecting that a patient reported that Respondent gave her the wrong medication. The medication was not

ordered or signed off on the Medication Administration Record (MAR). Respondent could not recall this event.

13. On or about June 11, 2007, an incident report was completed stating reflecting that Respondent failed to create new MAR's for a patient. As a result, all of the patient's medications were signed as administered on the wrong day. On or about July 6, 2007, Respondent admitted to this error.

14. On or about June 11, 2007, an incident report was completed stating reflecting that Respondent failed to transcribe new medication orders for a resident, resulting in the patient never getting not receiving the ordered the medication for a twenty-four hour period.

15. On or about June 25, 2007, Respondent received a written counseling for medication errors and rude behavior towards patients that occurred June 11, 2007 through June 17, 2007.

16. On or about July 7, 2007, the charge nurse, Lydia Della Rocca, received multiple patient complaints regarding Respondent's nursing care. The complaints included:

- A patient's daughter complained reported that Respondent gave the patient the wrong medication. Respondent admitted to the patient's daughter that she had administered the wrong medication. Administering incorrect medication(s) to a patient places patients at risk of harm and falls below minimum standards of care.
- A second patient complaint was received by the charge nurse that a patient had the wrong medication on his bedside table. The patient was supposed to receive Percocet but Norco was on by his bedside table instead. Respondent had signed out the correct medication, but could not explain how the Norco was provided got to the patient instead. The patient reported he had not

received any pain medications all night aside from the Norco. Administering incorrect medication(s) to a patient places patients at risk of harm and falls below minimum standards of care.

- After review of Respondent's assignments, additional errors and substandard performance was identified. Respondent placed MARS in the wrong patient rooms and patient medical records/charts, medications were not administered and circled as a refusal or medications were not given at all by Respondent. Placing incorrect MAR in patients' medical records/charts places falls below minimum standards of care and puts patients at risk of receiving incorrect medications and patient harm.
- The charge nurse reported she noticed that Respondent was unable to focus her thoughts on any one task at a time for any amount of time. Respondent's thoughts seemed scattered and she failed to there was no completion of any of the tasks required to take care of her patients. Based upon Respondent's inability to provide safe care to her assigned patient's, Respondent was relieved of her duties. Failing to complete assigned duties falls below minimum standards of care. The inability to focus and attend to patient care placed patients at risk of harm and falls below minimum standards of care. The charge nurse decided to send Respondent home.

17. On or about July 9, 2007, Respondent was dismissed from employment at Healthsouth.

18. From on or about July 30, 2007 until August 7, 2007, Respondent was employed at Brighton Gardens in Sun City, Arizona. Respondent was terminated from employment for the following narcotic discrepancies:

- On or about August 2, 2007, resident V.C. had an order for 1mg Ativan to be given as needed. Respondent removed one tablet of Ativan at 20:00, but did not record it on the MAR, Controlled Substance Countdown Sheet or the Progress Notes. At 00:30 on August 3, 2007, Respondent removed a second dose of Ativan. This was recorded this dose on the Controlled Substance Countdown Sheet, but did was not record it on the MAR. Respondent documented in the Progress Notes that the patient was agitated and an Ativan was given. The time listed documented for the entry was 00:30, but the date was listed was by documented August 2, 2007. Failing to maintain an accurate record of medications administered to a patient falls below minimum standards of safe care.
- On or about August 2, 2007, Respondent signed out two Oxycodone tablets at 21:00 for patient C.R. leaving a final count of 21. Respondent did not document the dose on the MAR nor was there any documentation on in the Progress Notes by Respondent identifying the need for Oxycodone and/or the patient's response to having received Oxycodone. .Failing to document justification for administering a controlled substance and the patient's response falls below minimum standards of safe care.
- On July 31, 2007, August 2, 2007 and August 3, 2007, Respondent removed one tablet of Oxycodone for resident E. R. Respondent did not document the medication was given or write a corresponding note on the dates identified. Failing to maintain an accurate record of medications administered to a patient falls below minimum standards of safe care. Failing to document justification

for administering a controlled substance and the patient's response falls below minimum standards of safe care.

- On or about August 2, 2007, Respondent signed out Vicodin, one tablet for resident D. L. at 20:00 and 02:00 on August 3, 2007, according to the narcotic flow sheet. Respondent did not document the times the medication was given. Failing to maintain an accurate record of medications administered to a patient falls below minimum standards of safe care. Failing to document justification for administering a controlled substance and the patient's response falls below minimum standards of safe care.
- Resident D.B. was ordered Xanax (Alprazolam) 0.5mg at 08:00am and 22:00pm. On or about August 2, 2007, Respondent signed out a single dose at 05:00. She did not document the doses as given in the Progress Notes and documented on The MAR shows the medication was administered at 22:00 and 08:00. Failing to maintain an accurate record of medications administered to a patient falls below minimum standards of safe care. Failing to document justification for administering a controlled substance and the patient's response falls below minimum standards of safe care.
- Resident D. T. was ordered Oxycodone 5/325mg two tablets as needed for severe pain. Respondent did not document the medication was given

19. In an interview with Board staff on or about March 4, 2008, Respondent stated she made an error by not documenting the medications. She realized she did not chart as required and attributed the errors to not having a lot of nursing home experience.

20. From on or about August 21, 2007 until September 16, 2007, Respondent was employed at Phoenix Mountain Nursing Center in Phoenix, Arizona. On or about September 16,

2007, Respondent was involuntarily terminated from employment due to her substandard performance.

21. From on or about September 18, 2007 until November 30, 2007, Respondent was employed at Scottsdale Nursing and Rehabilitation and Care Center. On or about November 30, 2007, Respondent was involuntarily discharged from employment.

22. On or about October 1, 2007, Respondent was employed with Maxim Staffing Solutions with an assignment at John C. Lincoln, North Mountain in Phoenix, Arizona.

23. On or about March 20, 2008, the Board voted to Issue an Interim Order for a neuropsychological and substance abuse evaluation to be completed by a Board approved psychologist and to include any testing deemed necessary by the evaluator to be scheduled within 15 days and completed within 45 days and then return to the Board. If the Interim Order was not completed, Notice of Charges was to be issued based upon the information contained in the investigative report. On or about April 24, 2008, Respondent underwent an evaluation with Scott Sindelar, PhD.

24. On or about April 22, 2008 and April 24, 2008, Dr. Scott Sindelar performed a neurological and substance abuse evaluation for Respondent. The evaluation showed Respondent's neurological status is in the normal range with a mildly impaired ability to solve problems and to think in abstract terms. Dr. Sindelar reported that Respondent has possible addiction issues. He recommended Respondent have one physician be aware of all of the medications she is taking and an addiction specialist should monitor her pain medications carefully.

25. On or about October 1, 2007, Respondent was employed with Maxim Staffing Solutions with an assignment at John C. Lincoln, North Mountain in Phoenix, Arizona.

26. On or about April 4, 2008, Board staff received a complaint from Paul Cisar, Accounts Manager at Maxim Staffing Solutions.

27. According to Cisar's complaint, Respondent displayed unusual behavior during her March 30, 2008 shift at John C. Lincoln including slow, uncoordinated movements, nodding off while in conversation and was witnessed also to have glassy eyes and asked disjointed questions. Staff members that were on duty with Respondent submitted their written statements describing Respondent's behavior.

- Respondent told a co-worker, "I talked to the supervisor and told him that she gave the pill that dissolves and that it would probably kill him. And there was that new story about a disaster..." Respondent did not finish her sentence and went back to looking at her charts.
- Respondent was assigned three patients. One had COPD, another had facial cellulitis and the last had a hand incision with drainage. Respondent stated, "I keep getting confused because they are all here for the same thing."
- When trying to reconcile the MARS for the next day, Respondent said, "I can't find the bird on the page that they told me to find. There was supposed to be a bird..." and did not finish her thought.
- Another nurse heard Respondent say things that did not make sense including "They told me to find the bird on the nursing notes" and accused patient care technicians of stealing her charts.

28. Respondent was assigned to care for three patients while on duty. In review of Respondent's documentation, the following below standard performance issues findings were identified: discovered:

- On or about March 29, 2008, Respondent pre-charted her assessment of all three assigned patients at 04:00 and 06:00. Respondent left the unit at approximately 02:15. Pre-charting assessments falls below minimum standards of care and constitutes false documentation, placing patients at risk.
- On or about March 29, 2008, patient E.E. was ordered Solumedrol 40mg IV every eight hours. Respondent failed to document giving a dose of Solumedrol at 2000 when it was required. Failing to administer medications as ordered by the provider falls below minimum standards of care and places patients at risk.
- The patient with the hand incision and drainage had a one line narrative charted, "Right hand I&D with complaints. Extremity wrapped with Morphine." The patient was alert and oriented and told the night nurse that he had not received medications for pain since 22:30.

29. The charge nurse, Michelle Jones, instructed the floor staff to not allow Respondent any further contact with patients. Respondent was escorted off the unit. Respondent's personal belongings were brought to Jones' office where Respondent had been escorted. Respondent's backpack was open and Jones saw a syringeless needle with a green hub. John C. Lincoln does not stock that type of needle.

30. On or about March 30, 2008, Respondent submitted to a "for cause" drug screen that was positive for Demerol, Morphine and Oxycodone. Respondent provided a prescription for the Morphine and Oxycodone but did not have a valid prescription for the use of Demerol. On April 10, 2008, Respondent informed Board staff that she may have stuck herself with a syringe that had Demerol in it. She stated she did not complete an incident report at the hospital.

31. A review of Respondent's prescription profile shows the following:

- In April 2007, Respondent received 180 Oxycodone ER 20mg capsules.
- In May 2007, Respondent received 60 Oxycodone ER 20mg capsules and 60 Oxycodone 5mg capsules.
- In June 2007, Respondent received 90 Oxycodone ER 20mg capsules and 180 Oxycodone 5mg capsules.
- In July 2007, Respondent received 120 Oxycodone 5mg capsules.
- In August 2007, Respondent received 3 Oxycodone ER 20mg capsules and 25 Oxycodone 5mg capsules.
- In September 2007, Respondent received 90 Oxycodone ER 20mg capsules and 120 Oxycodone 5mg capsules.
- In October 2007, Respondent received 45 Oxycodone ER 20mg capsules and 60 Oxycodone 5mg capsules.

In total, between April 2007 and October 2007, Respondent received 468 Oxycodone ER 20mg capsules and 565 Oxycodone 5mg capsules.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1663 (D) as defined in § 32-1601(16)(d) and (j); and A.A.C. R4-19-403 (B) (1), (7), (8), (16), (18) and (31) (adopted effective November 13, 2005).

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. § 32-1664(N) to revoke, suspend or take disciplinary action against the license of Respondent to practice as a professional nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact and Conclusions of Law.

In lieu of a formal hearing on these issues, Respondent agrees to issuance of the following Order and waives all rights to a hearing, rehearing, appeal, or judicial review relating to this Order, except in the limited circumstance(s) specified in Paragraph 16 of this Order.

Respondent understands the right to consult legal counsel prior to entering into the Order and such consultation has either been obtained or is waived.

Respondent understands that the term "Order" used throughout this document refers to all pages of the document including Findings of Fact, Conclusions of Law and all suspension/probationary terms and conditions and paragraphs of the Order.

Respondent understands that this Consent Agreement is effective upon its acceptance by the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by the Respondent, the agreement cannot be withdrawn without the Board's approval or by stipulation between the Respondent and the Board's designee. The effective date of this Order is the date the Consent Agreement is signed by the Board and by Respondent. If the Consent Agreement is signed on different dates, the later date is the effective date.

Pamela Renee Teets
Respondent

Dated: 6/13/08

ARIZONA STATE BOARD OF NURSING

SEAL

Az State Board of Nursing
4747 N. 7th Street, Suite 200
Phoenix, AZ 85014-3653

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: Joey Ridenour by MK Faber
7-28-08

ORDER

In view of the above Findings of Fact, Conclusions of Law and consent of Respondent, the Board hereby issues the following Order:

A. Respondent's professional nurse license number RN107237 is hereby **revoked**; however, the **revocation is stayed** for as long as Respondent remains in compliance with this Order. During the stay of the revocation, Respondent's professional nurse license number RN107237 is placed on suspension indefinitely until the Respondent completes the attached terms and conditions, followed by probation for twenty-four (24) months. Before termination of this Order, Respondent shall work as a professional nurse for a minimum of twenty-four (24) months (not less than sixteen hours a week).

B. If Respondent is non-compliant with any of the terms of the Order during the twenty-four month stayed revocation period, the stay of the revocation shall be lifted and Respondent's license shall be automatically revoked for a minimum period of 5 years. Except as provided in paragraph 16 of this Order, the Board or its designee, in its sole discretion, shall determine noncompliance with the stayed portion of the Order. With the exception of the provisions identified in Paragraph 16, Respondent waives any and all rights to any further review, hearing, rehearing or judicial review of any revocation imposed pursuant to this paragraph.

C. If Respondent is noncompliant with any of the terms of the Order during the twenty-four month standard probation portion of the Order, Respondent's noncompliance shall be reviewed by the Board for consideration of possible further discipline on Respondent's nursing license.

D. At any time Respondent is required by terms of the Order to provide a copy of the Order to another individual or facility the Respondent must provide all pages of the Consent Agreement and Order.

E. If Respondent is convicted of a felony, Respondent's license shall be automatically revoked for a period of five years. Respondent waives any and all rights to a hearing, rehearing or judicial review of any revocation imposed pursuant to this paragraph.

F. The suspension is subject to the following terms and conditions:

TERMS OF SUSPENSION (Stayed Revocation)

1. Surrender of License

Within 7 days of the effective date of the Consent Agreement Respondent shall surrender the license to the Board and Respondent shall not practice nursing indefinitely pending: 1) successful completion of a Board-approved Refresher Course and 2) successful completion of courses in nursing ethics. Violation of this paragraph is noncompliance with the Order.

2. Refresher Course

Within ninety days of the effective date of this Order, Respondent shall submit to the Board or its designee for prior approval a course outline/objectives of an educational course or program on documentation. The course may not be taken on-line and must include precepted clinical under direct supervision, pharmacology, documentation and physical assessment content. Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order based on the recommendation(s) of the course instructor.

3. Ethics Course

Within thirty days of the effective date of this Order, Respondent shall submit to the Board or its designee for prior approval, a course outline/objectives of an educational course or program on nursing ethics. Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order based on the recommendation(s) of the course instructor.

4. Violation of Indefinite Suspension

If Respondent violates the terms of Indefinite Suspension in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke Respondent's license or take other disciplinary action. If a complaint is filed against Respondent during the Indefinite Suspension, the Board shall have continuing jurisdiction until the matter is final, and the period of Indefinite Suspension shall be extended until the matter is final.

5. Completion of Indefinite Suspension

Following successful completion of the terms of Indefinite Suspension, as determined by the Board or its designee, Respondent's license shall be placed on 24 months Stayed Revocation Probation while employed in nursing. Respondent shall work as a professional nurse not less than sixteen hours a week subject to the following terms and conditions:

TERMS OF SUSPENSION AND PROBATION
(Stayed Revocation)

1. Renewal of License

If Respondent's professional nursing is expired at the time of the effective date of the Consent Agreement and Order, Respondent must renew the license within 7 days of the effective date. In the event the professional license is scheduled to expire during the duration of this Order, Respondent shall apply for renewal of the professional license and pay the applicable fee before the expiration date. Failure to renew within seven days of the effective date of this Order, if it is expired, or failure to renew a license by the last date in which the license is to expire, shall be considered as noncompliance.

2. Drug Testing

Within 7 days of the effective date of this Order, and throughout the term of this Order, Respondent shall remain enrolled in a program that meets Board criteria for random drug testing. Random drug testing shall be done at a minimum of twice per month, for the period of time this Order is in effect, and may be required more frequently as requested by the Board or its designee. Respondent shall notify the drug testing laboratory and the Board, **in writing**, of unavailability to test before the anticipated absence. If Respondent is unable to submit a specimen on a date requested due to illness, Respondent must provide in writing within 7 days of the missed specimen, documentation from a medical provider who has personally seen Respondent on the day of the requested drug test confirming that Respondent was not physically able to report to the laboratory for drug testing. **Otherwise failing to submit to a drug test on a day when a drug test has been requested by the Board, its designee, or the laboratory will constitute noncompliance with this Order, NOT subject to further review.** A positive drug test showing evidence of any drug other than an authorized drug shall result in immediate

notification of Respondent's employer by the Board. However, any occurrence of the following constitutes noncompliance with this Order, subject to further review if contested in writing by Respondent: a positive drug test showing evidence of any drug other than an authorized drug; submission of a specimen where the integrity has been compromised as indicated by the presence of adulterants; or submission of a urine sample that is below the acceptable volume or temperature to be tested. If contested by Respondent, Respondent shall, within five days of being notified of the non-compliance, submit a written request for further review and the reason(s) for contesting the results. **If so contested, the noncompliance shall be investigated by Board staff and reviewed and substantiated by the Board's designee, to include a written verification attesting to the validity and reliability of Respondent's drug screening results from the Toxicologist or Medical Review Officer affiliated with the drug screening laboratory. If so investigated, reviewed, substantiated and verified, the stay of suspension shall be lifted and Respondent's license automatically suspended, NOT subject to further review.**

3. Abstain from Alcohol Use

Respondent shall completely abstain from the use of alcohol.

4. Abstain from Unauthorized Drug Use/Proof of Prescription

Respondent shall completely abstain from the use or possession of controlled substances, and dangerous drugs as defined by law, or any drugs requiring a prescription.

Orders prohibiting Respondent from personal use or possession of controlled substances or dangerous drugs do not apply to medications lawfully prescribed to Respondent for an illness or condition by a medical provider. During the duration of this Order, Respondent shall select one medical provider to coordinate her health care needs and to be aware of all prescriptions utilized. Within 7 days of the effective date of this Order, Respondent shall cause

all medical providers who have prescribed medications which are currently being used by the Respondent daily or on an as needed basis to provide in writing, on letterhead, verification of knowledge of Respondent's history of substance use, awareness of Respondent's Consent Agreement and Order with the Board, and documentation of current medications prescribed for Respondent. Respondent shall execute all release of information form(s) as required by the Board or its designee so that Respondent's medical providers shall be able to communicate information with the Board. Prior to receiving treatment from any other medical provider(s), Respondent shall notify the medical provider(s) of Respondent's history of substance use and of the existence of the Order. DURING THE COURSE OF THE ORDER RESPONDENT SHALL CAUSE ANY AND ALL PROVIDERS TO NOTIFY THE BOARD OF THEIR AWARENESS OF RESPONDENT'S HISTORY OF SUBSTANCE USE, BOARD ORDER, AND NOTIFICATION OF ANY MEDICATIONS ORDERED BY THE PROVIDER. THE NOTIFICATION SHALL BE MADE IN WRITING WITHIN ONE WEEK OF THE PROVIDER'S ISSUANCE OF THE PRESCRIPTION.

If Respondent has a lawful prescription for a controlled substance, Respondent shall cause her prescribing provider to provide monthly reports to the Board regarding the continued need for the prescribed narcotic or mood-altering medications within 7 days of the 30th day of each month. The Board or its designee may, at any time, request the provider to document the continued need for prescribed medications. Such report from the provider shall be received by the Board within 14 days of the request. Respondent shall keep a written record of medications taken, including over-the-counter drugs, and produce such record upon request by the Board or its designee.

5. Pharmacy Profiles

Throughout the duration of this Order, Respondent shall use only one pharmacy from which to obtain her prescriptions. Within 30 days of the effective date of the Consent Agreement, Respondent shall submit in writing to the Board the name of every pharmacy and/or facility from which Respondent is currently obtaining prescription medications, and shall submit the name of the pharmacy from which she chooses to obtain future prescriptions. Throughout the duration of the Order, Respondent must inform the Board in writing within 7 days of any additions or changes in pharmacies from which Respondent obtains medications. Respondent shall submit a copy of all pharmacy profiles to the Board on a quarterly basis according to the assigned reporting due dates, and upon request from the Board or its designee. The first report shall be due on the first quarterly due date after the effective date of this Order.

TERMS OF PROBATION
(Stayed Revocation)

1. Stamping of License

Following completion of the Stayed Revocation Indefinite Suspension, Respondent's license shall be stamped "Probation" and returned to Respondent. While this Order is in effect, if the Board issues any certificates or licenses authorized by statute, except a nursing assistant certificate, such certificate or license shall also be stamped **"PROBATION."** **Respondent is not eligible for a multistate "Compact" license.**

2. Notification of Practice Settings

Any setting in which Respondent accepts employment, which requires RN, LP or CNA licensure, shall be provided with a copy of the entire Order on or before the date of hire. Within three (3) calendar days of Respondent's date of hire, Respondent shall cause her immediate supervisor to inform the Board, in writing and on employer letterhead,

acknowledgment of the supervisor's receipt of a copy of this Consent Agreement and Order and the employer's ability to comply with the conditions of probation. In the event Respondent is attending a nursing program, Respondent shall provide a copy of the entire Consent Agreement and Order to the Program Director. Respondent shall cause the Program Director to inform the Board, in writing and on school letterhead, acknowledgment of the program's receipt of a copy of the Consent Agreement and Order and the program's ability to comply with the conditions of probation during clinical experiences.

3. Monthly/Quarterly Reports

Within 30 days of the effective date of this Order, and monthly for the first twelve months and quarterly thereafter, Respondent shall cause **every** employer Respondent has worked for to submit to the Board, in writing, monthly employer evaluations on the Board-approved form. In the event Respondent is not employed in nursing or attending school during any quarter or portion thereof, Respondent shall submit to the Board, in writing, a self-report describing other employment or activities on the Board-approved form.

Receipt of confirmation of employment disciplinary action, including written counseling(s), suspension, termination or resignation in lieu of termination from a place of employment, any of which pertains to improper patient care, unsafe practice, inappropriate medication removal or administration, sub-standard documentation, or impairment on duty, positive drug test showing evidence of any drug other than an authorized drug, and/or refusal to submit to an employer requested drug screen/testing, shall be investigated by Board staff and reviewed and substantiated by the Board's designee. If so investigated, reviewed and substantiated, the employment disciplinary action shall be considered as noncompliance with the terms of the Order, and the stay of revocation shall be lifted and Respondent's license automatically revoked. If Respondent contests the lifting of the stay as it relates to this

paragraph. Respondent shall request in writing, within 10 days of being notified of the automatic revocation of licensure, that the matter be placed on the Board agenda for the Board to review and determine if the automatic revocation of Respondent's license was supported by substantial evidence. If the written request is received within ten (10) days of a regularly scheduled Board meeting, the request will NOT be heard at that meeting, but will be heard at the NEXT regularly scheduled Board meeting. Pending the Board's review, Respondent's license shall be reported as revoked – under review. Respondent may not work in any capacity involving nursing licensure pending the Board's review. The Board's decision and Order shall not be subject to further review.

Failure to provide employer evaluations or if not working in nursing, self-reports, within seven days of the reporting date is non-compliance with this Order and is not subject to further review.

4. Practice Under Direct/Preceptor Supervision

Respondent shall practice as a professional nurse or in a student nurse capacity, only under the direct/preceptor supervision of a professional nurse in good standing with the Board. 1) Direct supervision is defined as having a professional nurse present on the same unit with the Respondent when Respondent is practicing as a professional/practical/student nurse. 2) Preceptor supervision is defined as providing nursing care only in the physical presence of a professional nurse preceptor. The supervising nurse/preceptor shall have read this Consent Agreement and Order and shall provide input on Respondent's employer evaluations to the Board. The supervising nurse/preceptor shall be primarily one person, who may periodically delegate to other qualified professional nurses who shall also have read this Consent Agreement and Order. In the event that the assigned supervising nurse/ preceptor is no longer responsible for the supervision required by this paragraph, Respondent shall cause her new supervising

nurse/preceptor to inform the Board, in writing and on employer letterhead, acknowledging the new supervisor's/preceptor's receipt of a copy of this Consent Agreement and Order and the new supervising nurse's/preceptor's ability to comply with the conditions of probation within ten days of assignment of a new supervising nurse/preceptor.

5. Acceptable Hours of Work

Respondent shall work only the day or evening shift. Evening shift is defined as a shift that ends prior to midnight. Within a 14-day period Respondent shall not work more than 84 scheduled hours.

Respondent may work three 12-hour shifts in one seven day period and four 12-hour shifts in the other seven-day period, but Respondent may not work more than 3 consecutive 12-hour shifts during this probationary period. Respondent shall not work 2 consecutive 8 hour shifts within a 24 hour period or be scheduled to work 16 hours within a 24 hour period.

6. Registry Work Prohibited

Respondent may not work for a nurse's registry, home health, traveling nurse agency, any other temporary employing agencies, float pool, or position that requires on-call status.

7. Out of State Practice/Residence

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, the Board must first approve out-of-state practice or residence.

8. Violation of Probation

If during the stayed revocation portion of the Order Respondent is non-compliant with the terms of the Order in any way, the stay of revocation shall be lifted and Respondent's license shall be automatically revoked. If during the standard probation portion of the Order Respondent is noncompliant with the terms of the Order in any respect, the Board staff may notify the Respondent's employer of the non-compliance. Additionally, the Board may revoke probation

and take further disciplinary action for noncompliance with this Consent Agreement and Order after affording Respondent notice and the opportunity to be heard. If a complaint or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

9. Release of Information Forms

Respondent shall sign all release of information forms as required by the Board or its designee and return them to the Board within 10 days of the Board's written request. Failure to provide for the release of information, as required by this paragraph constitutes noncompliance with this Order.

10. Interview with the Board or its Designee

Respondent shall appear in person or if residing out of state, telephonically for interviews with the Board or its designee upon request and with at least 2 days notice.

11. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within 7 days of any change in nursing employment, personal address or telephone number. Changes in nursing employment include the acceptance, resignation or termination of employment.

12. Obey All Laws

Respondent shall obey all laws/rules governing the practice of nursing in this state and obey all federal, state and local criminal laws. Respondent shall report to the Board, within 10 days, any misdemeanor or felony arrest or conviction.

13. Costs

Respondent shall bear all costs of complying with this Order.

////

14. Voluntary Surrender of License

Respondent may, at any time this Order is in effect, voluntarily request surrender of her license.

15. Violation of Terms of Consent Agreement and Order

During the stayed revocation portion of the Order, if Respondent is non-compliant with the terms of the Order, the **stay of revocation shall be lifted and Respondent's license shall be automatically revoked**. If a complaint or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. Completion of Probation

Respondent is not eligible for early termination of this Order. Upon successful completion of the terms of the Order, Respondent shall request formal review by the Board, and after formal review by the Board, Respondent's nursing license may be fully restored by the appropriate Board action if compliance with this Order has been demonstrated.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: July 28, 2008

COPY mailed this 2nd of September, 2008, by First Class Mail to:
Pamela Renee Teets
18002 N 40th Place #109
Phoenix AZ 85032

By: Susan Barber, MSN, RN
Nurse Consultant, Hearing Dept.

EXHIBIT B

NOTICE OF REVOCATION

BEFORE THE ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY ACTION AGAINST REGISTERED AND PRACTICAL NURSE LICENSE NOS.: RN107237 AND LP031467 ISSUED TO: PAMELA RENEE TEETS	)	**NOTICE OF REVOCATION**

The Arizona State Board of Nursing hereby gives notice that the registered and practical nurse license numbers RN107237 and LP031467, issued to Pamela Renee Teets, are hereby revoked in accordance with the provisions of Consent Agreement and Order No. 0708008-NUR and is effective upon the date of this Notice of Revocation.

Pursuant to R4-19-404(B), Pamela Renee Teets may apply for reissuance of said license after a period of five years.

DATED this 28th day of August, 2009.

SEAL

ARIZONA STATE BOARD OF NURSING

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: August 28, 2009

JR/MM:bs

COPY mailed this 28th day of August, 2009, by Certified Mail No. 7009 0080 0000 0433 1540 and First Class mail to:

Pamela Renee Teets
18002 North 40th Place, #109
Phoenix, AZ 85032

By: Brent Sutter
Legal Secretary